

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-039248

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 168Primary Registration District No. 5594Registrar's No. 136

STATE FILE NUMBER

FILED NOV 15 1962

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RONALD McNAMEE</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in lb <u>14 9mo 17days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL INSTITUTE <u>St. Josephs Hill Infirmary</u>		d. STREET ADDRESS (If outside, give location) <u>1601 YALE AVE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>GOFFMAN</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/1897</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LOCAL COUNCIL IN TERMINAL R.C. SPRINGFIELD, IL</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>MICHAEL E. GOFFMAN</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE SLATTERY</u>	
14. NAME OF HUSBAND OR WIFE <u>ELLA M. CHANDLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes - I</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Do. Rev. St. Josephs Hill Inf.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC DECOMPENSATION</u> DUE TO (b) <u>VIRAL PNEUMONITIS.</u> DUE TO (c) <u>GEN ARTERIOSCLEROSIS WITH CEREBRAL AND CARDIOVASCULAR INVOLVEMENT.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC BRAIN SYNDROME</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>1/19/61</u> to <u>10/24/62</u> and last saw him alive on <u>10/24/62</u> Death occurred at <u>6:45 - A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Patrick b. Hogan</u> (Degree or title) <u>MD.</u>	
22b. ADDRESS <u>3664 South Grand St Louis 18 Mo</u>		22c. DATE SIGNED <u>10/31/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>Nov 3, 1962</u>	<u>Resurrection Cem.</u>	<u>St Louis Mo</u>
24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>Kutis Funeral Home</u>	<u>St Louis Mo</u>	<u>11-3-1962</u>	<u>Robert E. Bauer</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0500

2 24892

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9 422.1

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11

12 86-0

13 2-0

NOV 16 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Eliwan Province, Student Embalmer No. 3403

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eliwan Province

Licensed Embalmer No. 3403

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.